

Michigan Department of Military & Veterans Affairs  
Michigan Veterans Homes  
**APPLICATION FOR ADMISSION**  
**FOR THE GRAND RAPIDS HOME FOR VETERANS**  
3000 Monroe Ave. NE, Grand Rapids, MI 49505-3397

**Thank you for your interest in the Grand Rapids Home for Veterans. Your application will be given *immediate* attention.**  
You can help the application process by submitting the following documents or information with your application.

**Medical**

- ☐ Medical history and physical exam of the applicant within the past 90 days. (Required) Must use attachment #2, and provide additional medical information as needed or requested.
- ☐ Chest x-ray report of applicant within the past 30 days. (Required)

**Documents**

- ☐ DD-214 (Report of Separation, Military Record of Service or Enlistment Record.) For help obtaining this record please contact MI Veterans Trust Fund in Lansing for help (517) 335-1629 or the contact the county where the veteran resided at the time of discharge from service. [www.archives.gov/research\\_room/vetrecs](http://www.archives.gov/research_room/vetrecs)
- ☐ Copy of Social Security Card.
- ☐ Marriage certificate copy if currently married.
- ☐ Divorce papers or death certificate for all prior marriages of either the veteran or spouse if currently married.
- ☐ Widow(er) needs to submit marriage certificate and veteran's death certificate.
- ☐ For applicants with dependents, please fill out attachment #1.
- ☐ Birth certificates for all minor children being claimed as dependents.
- ☐ If applicable: Guardianship paper, Conservatorship paper, Power of Attorney, Durable Power of Attorney, Patient Advocate form.

**Insurance Information**

- ☐ Copies of insurance cards (front and back), including Medicare, Medicaid and secondary insurance if applicable.
- ☐ Copy of nursing care insurance policy if applicable.

**Financial**

- ☐ Verification of income and assets. This includes copies of any current bank account statements, land contracts, Social Security or other pension award letters or checks.
- ☐ **Call the Member Income and Assessment Office (616) 364-5382 to get an estimate of your projected monthly room and board assessment.** See Computation of Fees sheet for more information.

**Taxes**

- ☐ Must supply a copy of the past three year's Federal Income Tax forms if filed.

**Funeral Arrangement**

- ☐ Copies of any prepaid funeral arrangement papers.

**Wheelchair Rental**

If renting a wheelchair, check with your rental company to see if the insurance company will continue to cover the wheelchair after admission to a veterans' facility. (GRHV can provide a wheelchair after admission)

After the application is received, it is reviewed for completeness, eligibility and level of care. The applicant (or interested other party) will be notified by the Admissions Office to schedule an admission date and time, indicate placement on the waiting list or advise you if we are unable to meet the needs required.

At the time of admission, you will be asked to sign a Member Contract. The purpose of this contract is to outline your financial responsibility required to the Grand Rapids Home for Veterans for your cost of care, Supplementary Services and Member Rights & Responsibilities. **If you would like a copy of this contract prior to admission, please call us at 616-364-5382.**

**If you have any questions or wish to know the status of your application, please call:**  
**Admissions: Phone; 1-800-642-4838 or Fax; (616) 364-5373 or e-mail: [DMVA-Admissions@michigan.gov](mailto:DMVA-Admissions@michigan.gov)**  
**Member Finance: Phone; (616) 364-5382 Fax; (616) 364-5372**

Phone: (616) 364-5389  
Toll Free: 1-800-MICH-VET (1-800-642-4838)  
Fax: (616) 364-5373

## APPLICATION FOR ADMISSION

Phone: (906) 226-3576  
Toll Free: (800) 433-6760  
Fax: (906) 226-2380

Today's Date:			Filing Status: <input type="checkbox"/> Veteran <input type="checkbox"/> Non-Veteran			
<b>APPLICANT INFORMATION</b>						
Name of Applicant (Last, First, Middle)			Sex (M,F)		Birth Date	
Birth Place (City, State)			Social Security No.			
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what is your legal (former) name?			Have you ever been a resident of either facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter date:			
Permanent Address (Street & Number)		City	County	State	Zip Code	Primary Phone (     )
						Secondary Phone (     )
Temporary Address (Street & Number)		City	County	State	Zip Code	Phone (     )
Race/Ethnicity: <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic-American/Latino <input type="checkbox"/> Asian Pacific Islander <input type="checkbox"/> African-American/Black <input type="checkbox"/> Native American/Alaskan-American						
Referral Source <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Hospital* <input type="checkbox"/> Nursing Home* * Name of Facility _____ Phone No. _____ * Person Referring _____ Title _____						
Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated If married or widowed, please complete the following:						
Spouse's Name (maiden)			Date of Marriage	Date of Birth	Date of Death	
If married and either applicant or spouse had prior marriage, please complete (attach extra page if needed): How many times have you (applicant) been married before? _____ How many times has your current spouse been married before? _____						
Death or Divorce?	Name of Person	Date & County	Death or Divorce?	Name of Person		Date & County
Death or Divorce?	Name of Person	Date & County	Death or Divorce?	Name of Person		Date & County

**Line below is for office use only:**

Member Number					Level of Care	1 Domiciliary 2 Nursing 3 Special-Alzheimer's 4 Special-Main-1 Courtyard	Present Location					Admission Date		
							Bldg.	Floor	Area	Room No.	Bed			

**APPLICANT INFORMATION, Continued**

Religious Preference

Father's Name

☐ Living ☐ Deceased

Mother's Maiden Name

☐ Living ☐ Deceased

No. of Living Children (Please list below)

Name	Age	Street & Number	City	State	Zip	Phone

Do you have an advanced directive or some other directing medical care/decisions? ☐ No ☐ Yes (Please provide document)**EMERGENCY CONTACT INFORMATION/RESPONSIBLE PARTY****Responsible Party Name**

Relationship to Applicant

E-Mail Address

Street Address

City

State

Zip Code

Home Phone No.

Work Phone No.

Cell Phone No.

**Emergency Contact Name**

Relationship to Applicant

E-Mail Address

Street Address

City

State

Zip Code

Home Phone No.

Work Phone No.

Cell Phone No.

**Secondary Contact Name**

Relationship to Applicant

E-Mail Address

Street Address

City

State

Zip Code

Home Phone No.

Work Phone No.

Cell Phone No.

**Third Contact Name**

Relationship to Applicant

E-Mail Address

Street Address

City

State

Zip Code

Home Phone No.:

Work Phone No.:

Cell Phone No.:

**FUNERAL ARRANGEMENTS**

Funeral Home Preference (Name and Address)

Are Prepaid Arrangements Made? ☐ Yes ☐ No (Please provide a copy.)

Cemetery Preference (Name and Address)

Are Prepaid Arrangements Made? ☐ Yes ☐ No (Please provide a copy.)

MILITARY SERVICE INFORMATION				
A copy of the veteran's discharge or DD214 must accompany this application.				
<b>Wars Served In</b> <input type="checkbox"/> WWII <input type="checkbox"/> Persian Gulf <input type="checkbox"/> Korean <input type="checkbox"/> Iraqi Freedom <input type="checkbox"/> Vietnam <input type="checkbox"/> Other <input type="checkbox"/> Cold War	<b>Discharge Type from Service</b> <input type="checkbox"/> Honorable <input type="checkbox"/> Medical <input type="checkbox"/> Retirement	<b>Branch of Service</b> <input type="checkbox"/> Air Force <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Marines <input type="checkbox"/> Navy	<b>If Dependent of a Veteran</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Widowed <input type="checkbox"/> Spouse <input type="checkbox"/> Former Spouse	<b>Served in Combat</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Entered Combat: ____/____/____ Combat Ended: ____/____/____
Service Serial No.		VA Claim No.		
Date of Entry into Active Duty		Separation Date		
Residence at Time of Entry				
Place of Enlistment		Place of Discharge		
Did a veterans' service organization assist you with your claim? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please provide name of organization: _____				
INSURANCE INFORMATION				
Medicare No. (if covered)	Part A Hospital <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date		Part B Medical <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date	
Other Medical Coverage Claim No. <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Company Name of Insurance Carrier Address			
Prescription Coverage Claim No. <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Company Name of Insurance Carrier Address			
Dental Coverage Claim No. <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Company Name of Insurance Carrier Address			
Vision Coverage Claim No. <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Company Name of Insurance Carrier Address			
APPLICANT'S FINANCIAL DATA				
This financial statement <u>must</u> be completed and signed by applicant, spouse, guardian or responsible person. <i>All questions must be answered.</i> If the answer is none, put none.				
PERSON HAVING FINANCIAL RESPONSIBILITY IF OTHER THAN APPLICANT				
Name (Last, First, Middle)			Phone (    )	
Address (Street and Number)		City	State	Zip Code
Please check appropriate box: <b>NOTE: Please provide documentation for each box checked.</b>				
<input type="checkbox"/> Financially Responsible	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Conservator	<input type="checkbox"/> DPOA	<input type="checkbox"/> POA <input type="checkbox"/> Patient Advocate
Occupation of Applicant			Last Date Worked	
Former Employer			Years of Service	
Former Employer			Years of Service	
Automobile(s) – Year and Make				

<b>APPLICANT'S FINANCIAL DATA, Continued</b>				
MONTHLY INCOME		GROSS		NET
V.A. Disability Pension or Compensation		\$		\$
Social Security		\$		\$
Other Retirement Income (Source: )		\$		\$
Please list other income below:		\$		\$
1.		\$		\$
2.		\$		\$
3.		\$		\$
4.		\$		\$
5.		\$		\$
Rental Property Income		\$		\$
Land Contract Income (please provide a copy)		\$		\$
Dividends		\$		\$
Interest		\$		\$
Name and Address of Banks, Savings & Loan, Credit Unions		Type of Account: (please list) Savings, Certificate of Deposit (CD), Checking, IRA, Other		Amount
1.				\$
2.				\$
3.				\$
4.				\$
5.				\$
Name of Life Insurance Companies		Beneficiaries		Amount
1.				\$
2.				\$
<b>Are you or your dependents receiving, or will be receiving, long- or short-term nursing care insurance payments?</b> <input type="checkbox"/>				
<b>Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please provide a copy)</b>				
LOCATION OF REAL ESTATE				
Street Address	City	State	Zip Code	Value
1.				\$
2.				\$
OTHER INVESTMENTS – IDENTIFY				\$
1.				\$
2.				\$
3.				\$
4.				\$
5.				\$
6.				\$
Please provide past 3 years of federal income taxes if taxes were filed.				

**APPLICANT'S FINANCIAL DATA, Continued**

**Have you sold, transferred or created a joint tenancy (ownership) in any property within the last 36 months? (This includes cash and bank accounts.)**

**Applicant**   ☐ Yes   ☐ No

**Applicant's Spouse**   ☐ Yes   ☐ No

**If yes, to (or with) whom:**

**Date of Transaction:**

**In What Amount:**

**APPLICANT'S HISTORY**

**Have you ever been arrested or convicted of a felony?**   ☐ Yes   ☐ No   **Of a Misdemeanor?**   ☐ Yes   ☐ No

**If yes, please list all arrests and/or convictions:**

**Are you currently on parole/probation?**   ☐ Yes   ☐ No

Although a disqualification is possible, a previous conviction does not automatically disqualify and applicant of consideration for residency at the Home. However, if an applicant fails to reveal any previous arrest and/or convictions, s/he shall be **disqualified** for admission.

If at any time after being admitted, it was found that there was misleading, false, concealed and/or omitted information pertaining to having been arrested or convicted of a misdemeanor and/or felony, then the resident shall be **immediately** discharged from the Home.

**Please review your application and make certain that the information provided is accurate before placing your signature on this document acknowledging that all information provided is truthful and to the best of your knowledge.**

I, \_\_\_\_\_, further depose and say that I will, if admitted to the Facilities, agree to notify the Grand Rapids Home for Veterans or the D.J. Jacobetti Home of all changes in benefits or estate. I further depose and say that the foregoing questions have been carefully read by me or to me, and that the answers I have given to the same are true to the best of my knowledge and belief. I fully understand and agree that, if I am admitted to the Home, I must abide by the laws of the State of Michigan pertaining to the Home and the rules and regulations of the Home and hereby agree to pay the balance of any funds accumulated while a member.

☐ **Check this box to confirm agreement with the above statement.**

\_\_\_\_\_  
Applicants Signature

**Attachment No. 1 – Admission Application to Grand Rapids Home for Veterans**

<b>FINANCIAL STATEMENT FOR DEPENDENTS</b>				
<b>FOR VETERANS OR APPLICANTS WITH DEPENDENTS ONLY</b>				
<p>Applicants <b>WITHOUT</b> dependents, go on to Attachment No. 2</p> <p>This financial statement <u>must</u> be completed and signed by applicant, spouse, or conservator.</p> <p><i>All questions must be answered.</i> If the answer is none, put none.</p>				
Spouse's Name:		Social Security Number:		
Date Last Worked:				
INCOME SPOUSE AND/OR MINOR CHILDREN		MONTHLY INCOME		
		GROSS	NET	
Wages (Source: _____ )		\$	\$	
Social Security		\$	\$	
Other Retirement Income (indicate source below)		\$	\$	
1.		\$	\$	
2.		\$	\$	
3.		\$	\$	
Rental Property Income		\$	\$	
Land Contract Income		\$	\$	
Dividends		\$	\$	
Interest		\$	\$	
Other Income (indicate source below)		\$	\$	
1.		\$	\$	
2.		\$	\$	
3.		\$	\$	
Name and Address of Banks, Savings & Loan, Credit Unions		Type of Account: (please list) Savings, Certificate of Deposit (CD), Checking, IRA, Other		Amount
1.				\$
2.				\$
3.				\$
Automobile(s) – Year and Make				
Name of Life Insurance Companies		Beneficiaries		Amount
1.				\$
2.				\$
LOCATION OF REAL ESTATE				
Street Address	City	State	Zip Code	Value
1.				\$
2.				\$
OTHER INVESTMENTS - IDENTIFY				Value
1.				\$
2.				\$
<b>FINANCIAL STATEMENT FOR DEPENDENTS, Continued</b>				
LIVING EXPENSES AND INDEBTEDNESS		MONTHLY EXPENSES		AMOUNT
Food and Clothing				\$
Telephone				\$
Electricity				\$
Water & Sewage				\$
Heat				\$
Taxes				\$
Home Insurance				\$
Health Insurance (other than Medicare)				\$
Life Insurance				\$
Car Payments		Balance owed \$ _____		\$
Car Expense				\$

Rent or Mortgage Payment					\$
Other Expenses and Debts (indicate source below)					\$
1.					\$
2.					\$
3.					\$
4.					\$
5.					\$
<b>DEPENDENT CHILDREN</b>					
DEPENDENT CHILDREN INCLUDE THOSE UNDER 18 YEARS OF AGE AND THOSE WHO, BECAUSE OF A DISABILITY, ARE STILL CONSIDERED DEPENDENTS					
Name	Social Security Number	Birth Date	Source of Income (if any)	Amount	
1.				\$	
2.				\$	
3.				\$	
<b>MEDICAL EXPENSES</b>					
List All Medical Expenses (indicate source below)	Amount	Reimbursement Expected	Medical Costs Not Reimbursed		
1.					
2.					
3.					
4.					
5.					
6.					
<b>Michigan Felony Statute False Pretenses</b>					
Michigan Compiled Laws Annotated Section 750.218 provides:					
<i>“Any person who shall by any false token or writing obtain from this State Institution care and services, the value of which exceeds \$100 by intentional fraudulent misrepresentations or false signature before a notary shall be guilty of a felony punishable by imprisonment in state prison for a period not to exceed ten (10) years...”</i>					
It is unfortunate that a minority of veterans make false representations concerning their income and assets upon admission to this facility. <u>This detracts from the services we are able to provide and increases the monthly costs to the honest veterans.</u>					
<b>NOTICE AGREEMENT</b>					
For and in consideration of my admission to the Grand Rapids Home for Veterans, I hereby agree payment to the Board of Managers of the Facilities of any balance of money accumulated while a member of the Facilities, or due to me, or on deposit with any bank, trust company, corporation or with any individual, at the time of my death; provided all such sums shall be first expended to pay for residual maintenance costs attributable to the deceased individual, and shall then be paid to the spouse, minor children, or dependent mother or father in the order named.					
If no such relative shall be found within a period of two years, or if no claim for the sums has been made within a period of two years, the balance of the money shall escheated to State of Michigan, Department of Treasury, pursuant to the Michigan Uniform Unclaimed Property Act (Public Act 29 of 1995, as amended).					
I agree to notify the Grand Rapids Home for Veterans of any increases and decreases of income, assets, and expenses prior to the admission of this individual, and after his/her admission to the Grand Rapids Home for Veterans.					
Signed by: (Please check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Other responsible person					
Name (printed) _____					
Signature _____ Date _____					

**Attachment No. 2 – Admission Application to Grand Rapids Home for Veterans**

MEDICAL INFORMATION		
PHYSICIAN'S CERTIFICATE		
<i>The physician's certificate must be filled out and signed by the applicant's physician prior to the returning of this application.</i>		
Patient Name:	Date:	Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No
Current Diagnoses (if psychiatric, please attach recent assessment, progress notes, etc.)		
Height _____  Weight _____ Current        Normal	Open Wounds <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____ _____	Known Allergies (list) _____ _____ _____
Current medications. List method and frequency of actual administrations. If diagnoses do not justify medications ordered, please explain.		
Medication	Frequency	Diagnosis/Reason
Unstable Medical Conditions:		

<b>Disabilities:</b> <input type="checkbox"/> Amputation <input type="checkbox"/> Paralysis <input type="checkbox"/> Contracture <input type="checkbox"/> Wounds	<b>Impairments:</b> <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Sensation	<b>Activity Tolerance Limitations:</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Test:                      Date:  Chest x-ray  Lab work	Immunizations:    Date:  Tetanus Influenza Pneumonia TB Skin Test	Special Diet:  Restrictions:  Swallowing Problems:

[illegible]

Current Treatments:				Bed:                      Low Bed: <input type="checkbox"/> Yes <input type="checkbox"/> No					
				Mattress: <input type="checkbox"/> Regular <input type="checkbox"/> Firm <input type="checkbox"/> Specialty					
Prognosis:				Oxygen Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Special Needs:		<input type="checkbox"/> Catheter		<input type="checkbox"/> Colostomy		<input type="checkbox"/> Tracheostomy		<input type="checkbox"/> Feeding Tube	
		<input type="checkbox"/> IV		<input type="checkbox"/> Dialysis		<input type="checkbox"/> Fall Risk		<input type="checkbox"/> Latex Allergy	
Independent	Needs Assistance	Unable to Do	Check level of self-care ability:				Communication Ability:		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bathing				<input type="checkbox"/> Can Speak		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shaving				<input type="checkbox"/> Can Write		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral Hygiene				<input type="checkbox"/> Understands Speaking		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Problem				<input type="checkbox"/> Understands Gestures		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Problem				<input type="checkbox"/> Understands Writing		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing Lower Extremities						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing Upper Extremities				Appliances:		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeding						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting				<input type="checkbox"/> Eyeglasses <input type="checkbox"/> Prosthesis <input type="checkbox"/> Wheelchair		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Standing				<input type="checkbox"/> Dentures <input type="checkbox"/> Crutches		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking                      Distance				<input type="checkbox"/> Partial/Flipper <input type="checkbox"/> Cane		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair				<input type="checkbox"/> Hearing Aids <input type="checkbox"/> Walker		
Behavior/Orientation/Special Psychosocial Needs (please check all that apply):									
<input type="checkbox"/> Friendly		<input type="checkbox"/> Cooperative		<input type="checkbox"/> Quiet		<input type="checkbox"/> Alert			
<input type="checkbox"/> Confused		<input type="checkbox"/> Occasionally Confused		<input type="checkbox"/> Noisy		<input type="checkbox"/> Disoriented			
<input type="checkbox"/> Depressed		<input type="checkbox"/> Despondent		<input type="checkbox"/> Demanding		<input type="checkbox"/> Angry			
<input type="checkbox"/> Anxious		<input type="checkbox"/> Fearful		<input type="checkbox"/> Suspicious		<input type="checkbox"/> Withdrawn			
<input type="checkbox"/> Wanders		<input type="checkbox"/> Delusions		<input type="checkbox"/> Hallucinations		<input type="checkbox"/> Aggressive			
<input type="checkbox"/> Combative		<input type="checkbox"/> Inappropriate Behaviors		<input type="checkbox"/> Resistive to Care		<input type="checkbox"/> Verbally Abusive			
<input type="checkbox"/> Disruptive Behaviors		<input type="checkbox"/> Short-Term Memory Problems		<input type="checkbox"/> Special Psychosocial Needs					
<input type="checkbox"/> Socially Inappropriate		<input type="checkbox"/> Long-Term Memory Problems							
<input type="checkbox"/> Other:									
APPLICANT MUST SUPPLY THE WRITTEN RESULTS OF A CHEST X-RAY TAKEN WITHIN 30 DAYS PRIOR TO ADMISSION AND A HISTORY AND PHYSICAL COMPLETED WITHIN THE LAST 90 DAYS.									
EXAMINING PHYSICIAN									
Signature				Date		Phone (      )			
Name (printed)									
Address				City		State		Zip Code	
Signature of Person Completing Form: _____									
Telephone No.: _____ Relationship to Applicant: _____									